

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS639HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/29/2010
NAME OF PROVIDER OR SUPPLIER SUNRISE HOSPITAL AND MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3186 S MARYLAND PKWY LAS VEGAS, NV 89109		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>Initial Comments</p> <p>This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 7/29/10, in accordance with Nevada Administrative Code, Chapter 449, Hospital.</p> <p>Complaint #NV00025791 was substantiated with deficiencies cited. (See Tag S0310)</p> <p>Complaint #NV00025795 was substantiated with no deficiencies cited.</p> <p>Complaint #NV00025941 was unsubstantiated.</p> <p>A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included.</p> <p>Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p>	S 000		
S 310 SS=D	<p>NAC 449.3624 Assessment of Patient</p> <p>1. To provide a patient with the appropriate care at the time that the care is needed, the needs of the patient must be assessed continually by qualified hospital personnel throughout the patient's contact with the hospital. The assessment must be comprehensive and accurate as related to the condition of the patient.</p>	S 310		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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S 310	<p>Continued From page 1</p> <p>This Regulation is not met as evidenced by: Based on interview, record review and document review the nursing staff failed to follow the facility's skin risk assessment policy and procedure and implement more aggressive measures to prevent the development and exacerbation of skin breakdown on a patients buttocks, coccyx and sacral area. (Patient #2)</p> <p>Severity: 2 Scope: 1</p> <p>Complaint # 25791</p>	S 310			

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